How Public Health Administrators Perceive Their Constituencies

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THE TASKS of the public health administrator are multiple and require him to perform a variety of roles. One such role is that of a participant in the public policy process through which the nature and course of public health programs in his community, State, or nation are determined. His involvement in this process affords him opportunities to influence decisions concerning public health policy, as well as to become engaged in a series of relationships with groups and individuals, within and without government, who are concerned with such policy. He is called upon to function both as a spokesman for health interests and as a mediator between his fellow participants in the policy process and the persons or groups who have an expressed interest in health policies and programs. In these roles of spokesman and mediator, the public health administrator carries on activities not unlike those of a legislator relating to his constituency in an effort to define its needs and to initiate appropriate responses to them.

Method

To examine the representational role of the public health administrator, I have sought to explore the administrator's perceptions of relationships between his agency and its clientele. As in comparable studies of legislative bodies (*1*), it was necessary to distinguish between the focus of the representational role and the style of that representation. "Focus" refers here to the individuals or groups toward whom the representative directs his attention, while "style" means the manner in which he conducts these relationships with his constituency. A representative (administrator or legislator) may, for example, focus either upon a specific population or clientele or upon a broader segment of the public in terms of geography, interests, or population. He may be guided in his behavior by his conscience or by direct instructions from those with whom he has a primary relationship.

While differences in both focus and style will occur among administrators, several factors not present in the legislator-constituency relationship will affect the manner in which the administrator performs his role as a representative. He does not, for example, stand for election at periodic intervals, nor is his constituency normally defined in as precise geographic terms as that of a legislator. Consequently, it seemed best to pursue my inquiry indirectly by asking

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questions about (*a*) the responsiveness of the health agency to the persons and groups being affected by its actions, (*b*) the extent to which the agency consulted these groups in formulating health policy, (*c*) the concern of these groups for the activities of the agency, and (*d*) the manner in which the agency learned of these concerns.

Data to answer these questions were assembled from interviews in 1964 and 1965 with 29 administrative officials of two State health departments and of one Provincial health department in Canada. I conducted all these interviews with persons identified by their organization as constituting its top management and policy group. In each organization, the agency head, his immediate subordinates, and the major program chiefs were among those interviewed. The type and range of persons interviewed are shown in the table.

Several factors dictated the choice of the units in which the interviews were conducted. First, I was interested in learning if differences in organizational arrangements and political climates significantly affected the representational role of health administrators. Second, I wished to find out if an examination of the health administrator as a representative would explain more accurately the presumed differences in administrative behavior between health officials and the persons responsible for other areas of governmental activity. Third, since the project was conceived as an exploratory study, the number of organizations was kept to a minimum so that I could conduct the interviews, and the study could be fitted into budgetary and time restrictions.

The two State health departments, while comparable in many respects, had readily identifiable differences in their organizational structure and relationship with the chief executive of the State. The Canadian health agency was selected to examine the degree to which a different governmental and political environment would influence the representational style and focus of health administrators. All three governmental health units were picked to parallel a group of nonhealth organizations which were the subject of a larger study; thus, a direct comparison could be made with data from the larger undertaking (*2*).

Titles of persons interviewed in the three health departments, with interview number

Interview number	Respondent's title
	DEPARTMENT X
1.	Director
2.	Assistant to the director, administration
3.	Chairman, advisory council
4.	Associate director, medical services
5.	Associate director, laboratory services
6.	Head, adult health section
7.	Head, occupational and environmental health section
	DEPARTMENT Y
8.	Commissioner
9.	Assistant to deputy commissioner for program
10.	Director, public health administration
11.	Director, laboratory
12.	Director, mental health
13.	Director, industrial hygiene
14.	Director, tuberculosis prevention
15.	Director, environmental health
16.	Legal counsel
17.	Personnel chief
	DEPARTMENT Z
18.	Director
19.	Deputy director
20.	Deputy director
21.	Associate director, community health
22.	Assistant director, administration
23.	Assistant director, special services
24.	Assistant director, research
25.	Assistant director, environmental health
26.	Assistant director, hospitals
27.	Assistant director, chronic disease
28.	Assistant director, laboratories
29.	Chief, planning section

The interviews were conducted with a schedule containing closed as well as open-end items, which were organized around the following six major categories of information:

1. The groups the respondent viewed as being most directly affected by the work of his department.
2. Ways in which changes in program or policy were initiated, including the source of proposed modifications.
3. Groups outside the agency which were consulted on policy and why.
4. The degree to which the groups affected and consulted demonstrated an interest in the agency's activities and how the agency determined this interest.
5. Responsiveness of the agency to the needs of the groups affected by its operations and the basis for respondent's answer.
6. Respondent's employment history, mem-

bership and activity in professional organizations, and future employment or career aspirations.

Formulation of the interview schedule, coding of the responses, and analysis of the data were guided by two general hypotheses. First, given the doctrine that effective administration of health activities requires significant participation by a variety of health professionals in organizing programs, the representational focus of the health administrator would be on his fellow health professionals as opposed to the clientele of the agency. A distinction is made here between the persons concerned with health programs as providers of service—the health professionals—and the persons who are the consumers of that service—the clientele. The second hypothesis was that all health administrators, regardless of the specific governmental or organizational environment in which they functioned, would perceive their representational role in this way. This second hypothesis is derived from a concept gradually gaining acceptance in public administration: the most significant factor accounting for differences in administrative practice is the particular function being administered—health, highways, education, welfare, for example (*3*).

The first hypothesis would be supported by responses indicating that the health administrator primarily sought advice, information, and clearance concerning policy from health professional groups, defined the persons essentially affected by his agency as those engaged in health work, and perceived his political and administrative superiors as inhibiting the agency's capacity to achieve goals established by the health professionals. If this hypothesis were valid, the health administrator would see the impact of his agency's operations on the consuming public as an indirect one and perceive the role of the general public in the health policy process as less significant than that of the health professionals. Further, the health administrator would view his activities as representing primarily responses to the pressures from the producers of health services, and his responsiveness would be manifest in an extensive search for policy guidance from fellow professionals outside his immediate organization. All of the respondents, regardless of their particular responsibilities and the organizational or governmental setting in which they functioned, would look at their representational role in this way.

General Observations

Twenty-nine interviews in three agencies do not constitute a large enough sample from which to draw valid generalizations concerning the hypotheses tested in this study. Responses from the interviews, however, offer some indications of how the health administrator sees his representational activities. While preliminary, these perceptions are significant enough to merit reporting as a guide for researchers interested in pursuing a similar strategy in studying the dynamics of the health policy process. These data, morever, suggest the desirability of using the same approach in examing the health policy process. I am currently formulating a proposal to extend the investigation.

A first question in the interviews was the focus of the health administrator as a representative. Each respondent was asked, Which groups are most directly affected by the activities of your department? The answers were coded so as to distinguish between responses which indicated that the general population of the State or Province constituted these groups and those responses which specified that the health professionals constituted these groups. Sixteen respondents stated that the focus of their agency's concern was the general public. Exemplifying this position was the answer of respondent 8, that "There is not a single person in . . . who is not directly affected by the activities of the department. This department starts with the pre-natal stage and ends at the cemetery stage. . . . Any adverse effect on groups in . . . results directly from the regulatory actions that must be taken in order to benefit the greater number of people." Responses from 10 of the remaining interviews are typified by respondent 24, who said, "Most directly affected are the practicing health professionals. The audience of the department are the professional peers of its employees." Three respondents replied in terms similar to the response in interview 2. For example, one of them said, "Most directly affected are those who, because of economic or other reasons, are unable to purchase health services on the open market."

More interesting, perhaps, than this general breakdown of responses was their distribution among the three health agencies. The following table on the focus of the health units shows this spread and points out two questions which need further investigation:

Department	*General public*	*Special groups*
X	2	5
Y	6	4
Z	8	4
Total replies	16	13

The first question concerns the validity of the general hypothesis that the health administrator will focus on his fellow health professionals. Data from this preliminary study indicate that the reverse of this hypothesis may hold. A second question is whether this perception of focus would hold regardless of the organizational or governmental setting in which the health administrator operated. The distribution of answers between agencies X and Z raises doubts as to whether it would.

The manner in which the health administrator related to the groups he defined as his constituency was a second concern of this study. I sought the data indirectly by asking a series of questions about the sources of proposals for change in the agency's policy, what groups were consulted and why, and how the agency determined the interest of these groups in departmental activities. When the respondents were asked to identify the major source of proposals for policy or program changes, virtually all mentioned the agency staff. I anticipated this response, since studies of the public policy process reveal the important role that permanent members of the bureaucracy play in policy development (*4*). Therefore, each person interviewed was asked to identify the groups outside his organization which were asked about policy matters, the degree to which they were consulted, and for what purposes. Replies which emphasized consultation with practicing health professionals or persons or groups providing health services were considered to confirm the proposition that the health administrator seeks policy guidance primarily from health professionals outside his organization, rather than from persons directly served by his agency.

Data from the interviews clearly followed this expected pattern. Only one respondent stated that agency staff members did not consult with outside groups. Twenty-four said that the staffs of their agencies regularly sought advice and clearance from outside the agency. Sixteen of these 24 indicated that medical societies, dental societies, nursing associations, and similar organizations of health professionals were most frequently consulted, while the other eight mentioned various voluntary health organizations, such as the Tuberculosis Association and the Society for Mental Health, as the organizations the agency's staff most frequently consulted on policy questions. Unlike the responses about the focus of the health department's concerns, replies by the officials of the three agencies to this set of questions did not differ.

To a political scientist, the responses were interesting because only two of the respondents specifically mentioned consulting the representatives of political parties, legislators, or similar groups. Even when I drew attention to these groups as possible sources for policy guidance, the respondents minimized their influence and importance. Typical of the responses was the following from respondent 4: "When changes are being considered, listening is done primarily to organized medicine. Political parties, almost never."

In this part of the interviews, the respondents called attention to the close contact the departmental professional staff had with colleagues outside the department and outside government. While the influence of these relationships was difficult to establish precisely, most persons interviewed considered these relationships important in providing ideas for policy and program change. As respondent 12 said, "The impetus for policy change is difficult to assess. The technical staff plays a predominately important role in this process. However, since most of the technical staff are directly involved through memberships and other ways with various professional associations . . . , it is difficult to determine whether they are acting as professionals in the department or as representatives of these particular groups." Thus, while the respondents identified the agency staff as the prime source for policy modifications, they recognized the indirect influence that professionals outside the

organization exercise through professional relationships.

The importance assigned to these relationships led me to probe for a definition of what was meant by the influence of professional colleagues outside government and what was meant by close contact. Replies to my probes indicated that many members of the agency staff regularly attended meetings of professional societies and held offices in these organizations, in addition to reading journals and other professional publications. The data, however, were not clear enough for any extensive analysis of this issue.

The study explored the perceptions of the health administrator concerning the support and interest of the public and of special groups in his department's activities. According to 12 respondents, these groups demonstrated little or no interest in agency operations. Another 14 respondents said that they had observed a concern with departmental programs only when a specific issue directly affected one or another of the groups. Slightly more than half (15) of the respondents stated that their agency's efforts were supported, if at all, by professional organizations and only rarely by the groups directly served.

None of the agencies, moreover, tried systematically to gather information about the needs and concerns of those served as a means of generating interest in agency programs. They depended primarily upon unsolicited letters, complaints, and casual conversations with various persons for such information. All the respondents noted that a more systematic means was required for discovering these needs.

In reply to the question whether, in general, they saw their agency being responsive to the wishes of the people it serves, all but two respondents said the agency was responsive. One-third (9) of those who defined their agency as responsive qualified their responses by saying that the department was responsive to clientele needs as determined by a professional definition of these needs. A typical response was the following one given by respondent 6: "The department is responsive to needs as perceived by the department, not necessarily as perceived by the population. That is, it is responsive to needs as perceived by the professionals in the department."

Examination of the responses of the representatives of the three departments revealed differences similar to those noted earlier in the respondents' perception of their agency's constituency. As can be seen in the following table showing how responsive respondents considered their agencies, 10 of 12 respondents from department Z (the majority of whom defined their constituency as the general public) reported their agency was responsive without qualification. On the other hand, five of the seven respondents from department X reported that the responsiveness of their agency was qualified by professional standards.

Department	*Responsive—unqualified*	*Responsive—qualified*	*Not responsive*
X	1	5	1
Y	7	2	1
Z	10	2	---
Total replies	18	9	2

Examination of the data revealed two apparent differences in the overall responses from officials in departments X and Z. Respondents from department X not only tended to perceive their agency's constituency more narrowly than those from department Z; they also defined the responsiveness of their agency as more influenced by professional standards than did their counterparts in department Z. Review of the questionnaires suggests two possible reasons for these distinctions. All but one of the respondents in department Z had entered public health work directly upon completion of his formal professional training. In contrast, four of the seven respondents in department X had had extensive private professional experience before entering public health work. It may be hypothesized that persons for whom public health work is a first occupational choice have a greater tendency to perceive the constituency of their agency as the broad public and tend to view responsiveness less in terms of professional definition of needs then do persons for whom public health represents a secondary career choice.

A second reason for the differences may be related to the organization of the two State health departments. At the time of the study, the head of department X, while appointed by the Governor, served a specific term and could

not be removed from office during this term except for cause. In addition, his term was longer than that of the Governor. The head of department Z, however, not only was appointed by the Governor, but served at his pleasure. Further, he was a member of the Governor's cabinet and consulted regularly with both the Governor and members of his staff. One may hypothesize that the closer the organizational tie of the agency to the chief political head of the State, the more the administrative personnel in the agency will identify closely and directly with the broad public. Further, employees in a unit where the formal organizational relationship establishes a measure of independence for the department head will tend to identify more with their particular professional groups.

While data from this study were not adequate to test these propositions, a general review of the responses given by those interviewed in each department suggests that they may have some validity. Personnel in department Z generally described the policy process as involving close and direct consultation and cooperation with the Governor and the legislature, while those in department X saw the policy process much more as a matter of professional definition in the absence of close guidance from either the legislature or the Governor. Typical of the response from department X was the following answer from respondent 7: "The Governor's office has little influence on the organization. . . . The department makes the policy in public health." In contrast is the comment by respondent 24 in department Z: "The relationships between the Governor's office and the department are effective and close. . . . The department is dependent upon the Governor since legislation and the budget must originate with the Governor. While sometimes the relationship is restrictive in terms of budget controls, it is also supportative with the Governor seeking advice on needs in the health area."

Summary

Interviews with 29 health administrators from two States health departments and one Provincial (Canadian) health department in 1964–65 revealed varying perceptions of the relationship of the administrator's organization to the public which that organization served. The administrators had widely differing administrative responsibilities but were considered by their respective organizations as the top management of their units.

Sixteen of the 29 respondents suggested that their department's concerns focused on the public at large. Three of the 13 other respondents indicated that their department's activities primarily affected the clientele it served, and 10 held that the health professionals were the persons most directly affected by their department's work.

Both the variations and similarities in perceptions may possibly be explained by differences in the career patterns of the administrators and in the formally defined relationships between their agencies and the chief executive of the State or Province. These propositions, however, could not be tested fully with the data available. Such testing must await more extensive study in which various factors, such as level of government, type of function, and political setting, are held constant.

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